APPENDIX 7

PRIOR AUTHORIZATION PSYCHOTHERAPY ATTACHMENT (PA/PSYA)

MAIL TO:
E.D.S. Federal Corporation
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/PSYA

PRIOR AUTHORIZATION PSYCHOTHERAPY ATTACHMENT

1. Complete this form.
2. Attach to PA/RF (Prior Authorization Request Form)
3. Attach physician prescription.
4. Attach additional information if necessary.
5. Mail to EDS

RECIPIENT INFORMATION

(1) Last Name	(2) First Name	(3) MI	(4) Medical Assistance Identification Number	(5) Age
RECIPIENT	IM	A	1234567890	26

PROVIDER INFORMATION

(6) Performing Provider Name	(7) Performing Provider #	(8) Performing Provider's Telephone Number	Discipline (circle one)
I.M. PERFORMING		XXX-XXX-XXXX	MSW (MS) MD PHD DO PSYCH Other:

(9) Supervising Provider's Name	(10) Supervising Provider's Number	(11) Prescribing Provider's Name	(12) Prescribing Provider's Number
I.M. SUPERVISING		I. M. PRESCRIBING	12345678

A. Diagnosis: DSM-III-R Axis I: a) major depression, recurrent, in partial remission 296.35
b) Adjustment disorder with depressed mood. 309.00
Axis II: Rule out Historonic Personality disorder.
Axis III: Seizure disorder.
Axis IV: 1 2 3 (4) 5 6 7 8 9 0 (optional)
Axis V: (past year) 50 (optional) Highest GAF past year: 75

B. Date Treatment Began: 09/18/90 with this provider.

C. Diagnosed By: X Clinical Exam __ Psychological Testing X Other (specify): MAST Hookings Symptom Checklist 90.

D. Consultation: X Yes __ No Did consultant see recipient? X Yes __ No

E. Result(s) of Consultation: Medication & assessed for ability to progress in psychotherapy which was seen as positive.

F. Presenting Symptoms: Insomnia, anergy: suicidal ideation, history of 1 attempt 2 yrs ago, much guilt and self reproach.
Severity: __ Mild X Moderate __ Severe

G. Is the recipient's intellectual functioning significantly below average? __ Yes X No

H. If yes to "G", what is the recipient's IQ score or intellectual functioning level? N/A

I. Historical Data. Give relevant social and school history including development (if under 18), treatment history, past mental status, diagnosis(es), etc. (attach additional sheets if necessary): Im is from a step-family home with the step-father being "alcoholic." She was 14 years old when her step-brother committed suicide. Reported history of physical & sexual abuse in family of origin. Long history of depressed mood. Diagnosed as having major depression 1 yr ago when hospitalized at Anytown Hospital in Anytown, WI (12/03/89-12/31/89). No further treatment history. Seeking out help at this time due to husband being accused of abusing her 3 children. At time of hospitalization, reported being very suicidal & having some auditory hallucinations. Denies AODA usage. Currently well-groomed, pleasant, no signs of psychomotor retardation. Thought and speech intact. Very tearful. Admits to suicidal thoughts; no plans. Oriented in all spheres. (See attached intake summary sheet for additional history.)

APPENDIX 7 (Continued)

J. Present GAF (DSM): 50 Is the recipient progressing in treatment? X Yes __ No
If "no", explain:

K. Present mental status/symptomatology (include progress since treatment was initiated, or since last authorization):
Since treatment started 4 weeks ago, recipient is able to sleep most of the night. Continues to be tearful & hurt about abuse situation. Having more energy to care for self. Some lack of appetite continues. Periods of anxiety are often noted.

L. Updated/historical data (family dynamics, living situation, etc.):
Client is considering divorce. Still separated at this time.. Client's 3 children live with her and this has increased stress. We will begin to see her with children on an as needed basis.

M. Treatment Modalities: X Psychodynamic __ Behavior Modification __ Biofeedback
__ Play Therapy __ Other (specify): _____

N. Number of minutes per session: Individual: 60 Group: ___ Family: 60

O. Frequency of requested sessions: __ monthly X once/week X as needed twice/month __ other (specify): _____

P. Total number of sessions requested: 13 individual 6 Family

Q. Psychoactive Medication: X Yes __ No Has there been a medication check in the past three months?
X Yes __ No

Names and dosage(s): Desipramine 150 mgs h.s. and 200 mgs Dilantin for seizure disorder.
(total daily dose)

R. Rationale for further treatment:
1. Continues to have many life stressors (i.e. separation, child abuse, etc...).
2. Ongoing mild suicidal risk.
3. Beginning to explore own decisions around divorce with these stressors.
4. Therapy is essential to prevent rehospitalization.

S. Goals/objectives of treatment:
1. Continue to support & monitor mood; promote a positive self-image.
2. Continue to help in dealing with stress thru teaching cognitive as well as relaxation techniques for stress management.
3. Increase self-awareness of own past abuse and it's realtionship to current reality.
4. Begin to help with parenting skills.

T. What steps have been taken to prepare recipient for termination of treatment:
Have referred recipient to on-going self-help group to deal with past issues around family alcoholism. It is too early to start termination process at this time; however, we have discussed the time limited nature of the psychotherapy and have set a goal of terminating in 6 months.

U. Do you see other family members in a separate process? If yes, give rationale for seeing multiple family members:
No, not at this time. A family session for diagnostic purposes is planned in the near future.

J. M. Performing, MS		J. M. Supervising	MM/DD/YY
Signature of Performing Provider	Recipient Signature (optional)	Signature of Supervising Provider	Date

*The provision of services which are greater than or significantly different from those authorized may result in non-payment of the claim(s).